ILLINOIS ACADEMY OF FAMILY PHYSICIANS

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Illinois Academy of Family Physicians
Testimony before the Illinois Health Care Reform Implementation Task Force
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Good afternoon. My name is Dr. Dennon Davis and I am a family physician partner with Logan Primary Care in West Frankfort and medical director for the Franklin-Williamson bi-county health department. I am also a member of the Illinois Academy of Family Physicians Board of Directors.

I was asked to provide insight on these topics:

- Payment system reforms
- Challenges of assuring primary care in rural areas
- Fostering widespread adoption electronic health records and participation in the State's upcoming health information exchange.

Southern Illinois providers and electronic health records

Logan Primary Care has been using medical records for 10 years, making us among the first in the area to go electronic. LPC doctors can personally coordinate patient care across multiple practice sites for LPC as well as nursing homes and other facilities. Yet now the practice is waiting for their vendor to get ONC certification for their product and then make the necessary upgrades to Logan Primary Care so that we will be eligible for meaningful use incentives. Essentially our hands are tied for now. Once his EHR company's product is certified, we must still wait to see if the practice will need to make any hardware or server changes for the transition. Other practices are in similar situations. Getting practices in southern Illinois plugged in with electronic health records and integrated into the state's exchange will be challenging. Most are waiting for the list of ONC-certified products and then they can begin the long process of evaluating, selecting and implementing a system. IAFP is committed to assisting our members in accessing and maximizing the resources available through the HIT regional extension centers (REC) and federal incentive programs.

Other challenges:

- There are connectivity issues in Southern Illinois that are being worked out, but are currently a road block in some parts of the state.
- The federal government is still working to train Health Information Technology workforce to assist practices in adoption and implementation. So we don't have all the help we need yet.
- Providers need to decide if they should pursue Medicare or Medicaid Incentives, which is right for their practice?

Additionally, Illinois must distribute Medicaid incentive payments as quickly as possible in 2011 – doing so will allow safety-net providers the resources to meet the meaningful use criteria. *Obviously any delay in payments to the first providers will discourage other Medicaid providers from moving ahead if they fear that the payments will not be there when they need it.*

The AAFP believes the federal government must switch its emphasis from a focus on hospitals and large enterprises to one that helps networks of small and medium-sized physician offices acquire affordable and interoperable HIT systems.

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We need to link these offices so that primary care physicians, specialist physicians, pharmacists, and hospitals can communicate, locally as well as across the globe, to provide integrated, coordinated, quality care for all patients. Connected medical homes are more likely than other practices to be able to automate the patient care processes necessary for quality improvement and accountability, as well as for public health and bioterrorism protection. To ensure a return on investment, data collection should be the by-product of the use of EHRs in connected medical homes, and not the reason they are purchased in the first place.

Providing Differential Payments to Physicians Who Use HIT Effectively
Special payments should reward physicians who can demonstrate the use of EHRs and other HIT as a way to improve and coordinate care. Current reimbursement methods tied to face-to-face visits discourage efficiencies brought about by the use of EHRs, for example, asynchronous communication with patients using secure email and web-based consultations. Reimbursement strategies must change to reward quality and efficiency enabled by HIT.

Target Federal Dollars to Support Physicians Who Are Serving the Underserved
Any specific payments to physicians to purchase HIT systems should go to those serving in underserved areas where the capital to purchase EHRs is hardest to obtain and practices may be small or medium-sized. These payments should not go through third-parties such as hospitals, integrated health systems, or health plans, but directly to clinics and practices based on financial need.

Tomorrow's physicians will grow up using computers and electronic health records. As an Academy, we are committed to helping all practicing family physicians make the challenging but necessary transition with the support of the state's regional extension centers.

Supply and demand of health care workers across the state
Most importantly, I cannot stress enough the importance of building up family medicine in this process. Family physicians do it all in providing health care services in our state, especially in rural locations. Family doctors provide pre-natal care, deliver babies, treat children and care for adults through the end of life. No other specialty has a broader scope of expertise.

Family physicians are the backbone of rural primary care, and a resource that must be replenished quickly. Our national organization, the American Academy of Family Physicians projects that Illinois will need an additional 1,000 family physicians more than our current level to meet demands for services that we will see by the year 2020. **Basically we need to ramp up family physician production by 30 percent.**

We are already near the end of the year 2010. Today's first-year medical student could be a practicing family physician by 2017. So if we hope to shore up our supply of family physicians in 2020, we need to start moving those numbers up now.

How to quickly address payment reform
In our current system, primary care is underpaid. We must reform **how** we pay providers, not just *how much we pay for their services*.

There are several payment models currently in use or in pilot testing around the country. I would like to suggest the **Blended Payment** model for Illinois. As the name suggests, a blended payment model combines different approaches. It begins with the standard fee-for-services provided in the practice. Next you add in the "care management fee" which covers all the aspects of providing care to that patient outside of the exam room. I could list all the things that primary care practices do for patients before and after that exam room visit, but that would put me well over my five minutes. Finally we add "pay for performance" to the mix. This is where the extra work meets the reward. When patients are healthier, their cost to the system goes down. By providing better care and reporting that information back, providers who are at the top of their field should be rewarded for that effort.

Illinois' Medicaid program already has some of these concepts in place. Many Medicaid patients now have medical homes, built through the Illinois Health Connect program. The state's disease management program, Your Healthcare Plus, has shown promise in lowering overall health care costs by providing better timely care to the chronically ill, thus preventing unnecessary emergency room visits and hospitalizations.

Both of these programs are powered by primary care physicians and provide patients with a medical home, a first point of care and a physician who knows them. Illinois Health Connect provides per member per month payments to primary care physicians for coordinating their patients' care beyond the office visit, and bonuses for exceeding quality measures.

In essence, the program pays for the good work that primary care providers have always done, but have not been paid for in the traditional fee for service system.

These programs work and are essential to achieving long-term cost-savings in the Medicaid and state health plans. Their success should be shared, duplicated and expanded. It's not a one-size fits all solution. While Illinois Health Connect has standard per member per month fees, the care management fee really needs to be determined based on the practice's patient panel – which is unique to the community and the demographics of the practice.

The blended model is evolutionary, but not revolutionary. These system changes can be easily implemented, especially important in our quest to make health care better – sooner! Because there are models in place already, these changes should be acceptable to all payers in the system. And we do need the payment system to be standard across all payers. What does that mean? The blended model needs the right mix of ingredients: We suggest a blend with a formula of 50 percent for the fee-for-service charges, with 20 percent towards the care management fee and finally a 30 percent mix of the pay for performance measures. To improve that care management fee proportion of the blended payment mix, CMS experts suggest a three-tiered approach of $30, $40, and $50 per member-per month for chronically ill patients, and concurrent with the tier that the practice achieved in the patient centered medical home recognition by the National Committee on Quality Assurance. Essentially these three tiers coincide with the level of services provided by the providers in a patient-centered medical home. For practices that are not NCQA recognized, a similar care management fee schedule should reflect something close to those levels.

So what are the drawbacks? This blended model would still rely largely on the Resource Based Relative Value System for the fee for service portion of the payment formula, which still undervalues primary care services. And for Illinois and most states, the question remains "how are we going to pay for this?" And I don't have the solution for the Illinois budget crisis.

IAFP and family physicians are ready to move full speed ahead in health care reform. We ask that the state follow these recommendations to support today's family physicians in our common mission to recruit and train more high-quality family physicians, providing the best possible care to all patients… of all ages… in every part of the state.

I thank you again for the opportunity to speak and welcome any questions you have.

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